

SOCIAL SERVICES PAYMENT SYSTEM (SSPS)  
**PAYMENT ADJUSTMENT**

1. Type of adjustment: ☐ 1a. Underpayment (under claim)  
☐ 1b. First time authorization of old
2. Authorization number: \_\_\_\_\_
3. Case number: \_\_\_\_\_
4. Reporting unit: \_\_\_\_\_
5. Worker ID number: \_\_\_\_\_
6. Provided by: \_\_\_\_\_

\_\_\_\_\_  
ADDRESS STREET  
\_\_\_\_\_  
CITY STATE ZIP CODE

- 6a. Provider number: \_\_\_\_\_
- 6b. Social Security Number: \_\_\_\_\_ **OR**  
Federal Tax ID number: \_\_\_\_\_
7. Provided by: \_\_\_\_\_

\_\_\_\_\_  
ADDRESS STREET  
\_\_\_\_\_  
CITY STATE ZIP CODE

- 7a. Provider number: \_\_\_\_\_
- 7b. Social Security Number: \_\_\_\_\_ **OR**  
Federal Tax ID number: \_\_\_\_\_
8. Service recipient: \_\_\_\_\_

LAST NAME FIRST NAME

9. Service line: \_\_\_\_\_ Service code: \_\_\_\_\_  
Reason: \_\_\_\_\_ Source of funds: \_\_\_\_\_  
Begin date: \_\_\_\_\_ End date: \_\_\_\_\_  
Rate: \_\_\_\_\_ Unit: \_\_\_\_\_ # of Units: \_\_\_\_\_  
Adjusted amount: \_\_\_\_\_

10. Service recipient: \_\_\_\_\_

LAST NAME FIRST NAME

11. Service line: \_\_\_\_\_ Service code: \_\_\_\_\_  
Reason: \_\_\_\_\_ Source of funds: \_\_\_\_\_  
Begin date: \_\_\_\_\_ End date: \_\_\_\_\_  
Rate: \_\_\_\_\_ Unit: \_\_\_\_\_ # of Units: \_\_\_\_\_  
Adjusted amount: \_\_\_\_\_

12. Should OASI be withheld from payment? ☐ Yes ☐ No

**INSTRUCTIONS FOR USE**

- 1a.** Check this box if underpayment. See SSPS Manual 01/10 for definition of underpayment.
- 1b.** Check this box if the service period is more than 180 days prior to the current invoice month. **Attach copy of authorization: 14-159 preferred, and any other SSPS system verification of non-payment.**
- 2.** Item 2 on DSHS 14-154/14-159. 7 digit basic # only.
- 3.** Case number used by office in #4 of this form.
- 4.** RU number of worker completing form.
- 5.** Worker ID of worker completing form.
- 6.** Items 7 - 11 from DSHS 14-154/14-159.
- 6a.** Item 8 from DSHS 14-154/14-159.
- 6b.** Enter provider's Social Security Number OR Federal Tax Identification Number. If both are known, use Federal Tax Number.
- 7.** Items 12 - 16 from DSHS 14-154/14-159 if applicable. Complete only if different from 6 above.
- 7a.** Item 13 from DSHS 14-154/14-159.
- 7b.** Enter provider's Social Security Number OR Federal Tax Identification Number. If both are known, use Federal Tax Number.
- 8.** EXACTLY as appears on DSHS 14-154/14-159, item 26. Enter last name, first name.
- 9.** Enter information from DSHS 14-154/14-159 service line (1 - 4), items 31 through 41. Enter only the dates for which you are requesting payment. Must be within dates authorized. One ONE CALENDAR MONTH per line unless the amount due is the same EVERY month. Enter the number of units your are requesting per month not to exceed item 42 on the DSHS 14-154/14-159. Deduct participation if applicable before entering adjusted amount. Enter the adjusted amount due (per month).
- 10.** EXACTLY as appears on DSHS 14-154/14-159, item 26. Enter last name, first name.
- 11.** Complete 10 only when requesting a second adjusted payment from the same authorization.
- 12.** Check YES or NO for OASI deduction.

COMMENTS OR REASONS FOR ADJUSTMENT

SIGNATURE OF WORKER COMPLETING THE FORM

DATE

TELEPHONE NUMBER

SIGNATURE OF SUPERVISOR

DATE

FOR STATE USE ONLY